

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-025616

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 18

STATE FILE NUMBER

AMENDED

FILED JUL 20 1961

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>WASHINGTON TWP</b> OR TOWN <b>MARTIN CITY</b>		Length of stay in 1b <b>12 YEARS</b>	c. CITY OR TOWN <b>MARTIN CITY</b> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>213 E. BLUE RIDGE EXT.</b>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>213 E. BLUE RIDGE EXT.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>DILL</b> Last <b>HOGAN</b>			4. DATE OF DEATH Month <b>7</b> Day <b>13</b> Year <b>1961</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/3/1895</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POSTMASTER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T</b>	11. BIRTHPLACE (City and state or country) <b>MARTIN CITY, MO. NASHVILLE, TENN.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>GEORGE WASHINGTON HOGAN</b>	13b. MOTHER'S MAIDEN NAME <b>ADA COE DILL</b>	14. NAME OF HUSBAND OR WIFE <b>MRS. LINNIE HOGAN</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b> <b>WORLD WAR I</b>	17. INFORMANT <b>MRS. LINNIE HOGAN</b> Address <b>213 E. BLUE RIDGE MARTIN CITY, EXT</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **1:30 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <b>Rudolph Owens Corner</b>	22b. ADDRESS <b>152 Union Station</b>	22c. DATE SIGNED <b>7-13-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JULY 15, '61</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>MEMORIAL PARK CEMETERY KANSAS CITY</b>	23d. LOCATION (City, town, or county) (State) <b>MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS KANSAS CITY,</b>	25. DATE RECD. BY LOCAL REG. <b>7-15-61</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

JUL 20 1961

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Oern Lawler

Licensed Embalmer No. 4915

P. O. Address KG MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.